

INFORMED CONSENT FOR CROWN LENGTHENING SURGERY

PATIENT NAME: _____

DATE OF BIRTH: _____

DIAGNOSIS: After careful examination and study of my medical and dental conditions, my doctor has advised me that I would benefit from crown lengthening procedures in the following area(s):

PURPOSE OF TREATMENT: The purpose of my recommended crown lengthening surgery:

- Tooth #(s) _____ lack(s) sufficient height to retain planned crown(s)/veneer(s)
- Decay or tooth fracture on tooth #(s) _____ extends beneath the gumline
- Excessive gingival tissue causes tooth #(s) _____ to appear short & unesthetic
- Other: _____

BENEFITS OF CROWN LENGTHENING SURGERY:

- **Functional crown lengthening.** When the need for crown lengthening is due to a *lack of sufficient tooth height to retain a crown/veneer*, the dentist, by removing and recontouring gingival tissue and bone, will expose more of the remaining tooth structure to the oral cavity, making a cemented crown or veneer more retentive. In some cases, the doctor has recommended a crown lengthening surgery in order *to gain access to areas of the tooth which are hidden beneath the gumline* – in order to treat *dental decay, fractures and other tooth defects*. Generally speaking, the gum tissue will be gently reflected, and underlying bone and soft tissues will be recontoured and reshaped to provide the dentist with the access to visualize and restore areas of the tooth which would otherwise be concealed from view.
- **Esthetic crown lengthening.** Crown lengthening surgery can also be recommended for *esthetic reasons (gingivectomy – removal of gum tissue only)*. In some cases, excess gingival tissue conceals portions of the tooth, making it appear shorter and less attractive. In other cases, gum tissue levels are asymmetrical and unesthetic. Removal, recontouring and reshaping of excess gum tissue can dramatically improve the appearance of the tooth/teeth. I understand that certain medications promote gingival overgrowth & that future re-treatment may be required to maintain esthetic results. I also understand that there is no way to predict how tissues will heal & that gingival tissue symmetry & desired esthetics may not be achieved.

RISKS AND COMPLICATIONS: In general, crown lengthening surgery is performed under **local anesthetic**. Depending upon the amount and type of tissue that requires removal and/or recontouring, surgery may involve placement of sutures and/or a periodontal dressing.

Sometimes complications may result from crown lengthening surgery or from anesthetics or drugs administered. These complications include, but are not limited, to *post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days/weeks, impact on speech, allergic reaction (potentially life-threatening), anesthetic overdose, accidental swallowing of foreign matter, tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods and transient (on rare occasions, permanent) numbness of the jaw, lip, tongue, chin or gums*. The exact duration of any complication cannot be determined; complications may be irreversible. **Females:** Females prescribed an antibiotic should use an additional form of birth control for one complete cycle (other than birth control pills) after a course of antibiotics is completed.

There is no method to accurately predict, prior to treatment, how the gums and bone will respond to surgery. I understand that there may be a need for a second surgery if the initial results are not satisfactory. In some cases, the doctor may have to change, modify or terminate the original surgical plan based on my clinical conditions. I also understand that in rare cases, my doctor may determine that tooth extraction (*removal*) is necessary because extensive decay or fracture has rendered the affected tooth/teeth non-restorable. I understand that as my gum tissue heals from

surgery, tissue shrinkage may expose sensitive root surfaces of my teeth. I also understand that certain medications promote gingival overgrowth and that re-treatment, at additional fees, may be required to maintain treatment results.

TREATMENT ALTERNATIVES: Alternatives to crown lengthening surgery include:

- 1) **No treatment.** I understand that without crown lengthening surgery, successful restoration of my tooth/teeth may not be possible and/or esthetics may be compromised.
- 2) **Tooth extraction** (*removal*).

FOLLOW-UP/SELF-CARE: I understand that it is my responsibility after crown lengthening surgery to return for recommended post-operative checkups. Should I experience post-operative complications such as excessive bleeding, swelling, fever or malaise, I will contact this office right away. I have informed my doctor of all pertinent medical conditions, allergies, and any over-the-counter medications that I'm taking. I have been informed that smoking, poor oral hygiene and excessive alcohol use have a very negative effect on wound healing.

NO WARRANTY OR GUARANTEE: Although crown lengthening surgery is usually successful, no guarantee, warranty or assurance has been given to me in regard to the proposed surgical procedure. Despite the very best of care, individual differences make it impossible to ensure that every surgery is successful.

Initials: _____

INFORMED CONSENT: I can read and write English and have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment (***crown lengthening surgery***) and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. I have been informed of my diagnosis, the planned procedure(s), the risks, benefits and alternative treatments associated with this procedure. If I elect to have any additional forms of anesthesia other than local anesthetic, I agree to review and sign **separate informed consents**, after discussion with my doctor.

By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.



CONFIRMATION OF MEDICAL HISTORY:

| | | |
|-----|----|--|
| YES | NO | History of taking bisphosphonates for metastatic bone cancer ; Treatment year: _____ |
| YES | NO | History of taking bisphosphonates for osteoporosis : (i.e. Boniva, Fosamax, Actonel, Reclast, etc.) |
| YES | NO | Radiation treatment to the head or neck area |
| YES | NO | Bleeding problems |
| YES | NO | Taking blood thinner medications or daily aspirin |
| YES | NO | Taking anticoagulants (i.e. Coumadin, Plavix, Lovenox, Fragmin, Angiomax) |
| YES | NO | Predisposed to food allergies, asthma or hives |
| YES | NO | Pregnant, recent pregnancy or nursing |
| YES | NO | History of taking <i>phenytoin, PHT, mephenytoin, valproate, phenobarbitone, vigabatrin, primidone</i> |
| YES | NO | History of taking <i>cyclosporin, sirolimus, tacrolimus, ethosuximide</i> |

Patient name (printed): _____

Patient/guardian name (signature): _____ **Date:** _____

Relationship to patient: Self; _____

Signature of Dentist: _____ **Date:** _____